THE MEDICAL CARE PROGRAM
for
FARM SECURITY ADMINISTRATION BORROWERS

More than 100,000 low-income U. S. farm families, or about 500,000 persons, have banded into groups to obtain adequate medical care at a cost they can afford. Started in a few rural counties five years ago, this medical care program now extends into over 800 counties in 33 States.

The desperate economic situation in which one-fourth of the farm population found itself during the depression gave impetus to the medical care program. More than a million and a half farm families were trying to exist on an average income of less than $500 a year. For these eight million persons, there was an average income of about $2 a week each. With such a standard of living, many thousands of farm people and their children often went hungry. Their health and sanitation standards were almost unbelievably bad.

The Rehabilitation Program

Fortunately a way has been found to help this distressed part of the farm population climb back toward health and security. To the poorer farm families--those overburdened with debt, working eroded soil and fighting against low market prices--the Farm Security Administration is making small operating loans ranging from about $100 to $800.

To receive a rehabilitation loan, a farmer must be unable to obtain satisfactory credit from any other source, public or private; he must have farming experience, be able to run a farm, and must be located on a farm at the time the loan is made. He must also be physically able to do farm work. Finally, a county committee which includes local farmers must vouch for his character and ability.

Rehabilitation loans have helped more than 860,000 farm families to stay off relief. Aided by loans, they have purchased a much needed horse, mule or plow, a pressure cooker, seed, and sometimes food and clothing for the family. Guidance in home and farm planning, as important as the credit extended, has gone far toward assuring rehabilitation.

Farmers on the rehabilitation program outline their farm plans each year with the help of county supervisors. Instead of raising

only one cash crop, the farmer raises two or three to minimize effect of one crop failure. He grows feed for his livestock, plants a garden to supply his family with vegetables and fruit, and follows soil-improving practices suggested by the supervisor.

At the same time, home management supervisors teach farm wives to use pressure cookers, so that home-grown vegetables may be canned; help them to make over clothing to prevent inroads on the family's slim budget, or show them how to make attractive furniture out of available material.

Health is Essential

Most rehabilitation borrowers are repaying their loans and becoming self-supporting. From the early days of the rehabilitation program, however, it was evident that other families with equal opportunities were making slow progress. It was found that poor health was one of the primary factors which kept many of these families from becoming self-supporting. In certain States, from fifteen to twenty percent of the complete failures were due primarily to ill health.

Complete physical examinations of borrower families in sample counties in Maine, Missouri, Ohio, and South Carolina showed an average of 3.53 physical defects per person among 3,068 individuals examined. Of 1,005 heads of households and wives in white families, only 5 had no defects. Among 111 colored persons in the same category, there was not one free of defects. Four or more defects per person were found in 45.5 percent of white persons of all ages, and in 50.9 percent of colored persons. Dental defects in these cases, no matter how numerous, counted as only one defect per person.

Surveys and studies only confirm what is common knowledge to the supervisors working with these low-income families. They have seen farmers dragging along for years with malaria, hookworm disease, hernias, abscessed teeth or other chronic conditions. Many of these people have hesitated to consult a doctor, knowing that they could not pay the bills for medical care. They have let minor ailments go until they became grave. Then the family's livestock or farm tools have often had to be sold at a sacrifice to pay for a serious operation or prolonged hospital care.

Because it is unpredictable, acute sickness often has thrown out of balance the carefully developed plan charting a family's course toward rehabilitation and financial independence. To offset this, the

Farm Security Administration is developing a health program for its borrowers which is becoming broader and more effective each year. Plans for medical, dental, and hospital care are in a sense more dramatic than adequate nutrition, better housing, environmental sanitation, and full utilization of public health facilities, but all are equally stressed.

The health program for these families takes on new meaning in the present defense emergency. The health of the rural population is inseparable from the health of the Nation's defense forces. Rural areas contribute more recruits in proportion to their population than do cities and large towns. Physical examination of drafted men has revealed alarmingly how physical defects disqualify men from active service. The correction of defects, the prevention or control of defects and impaired health in general, and the promotion of positive health are vitally important to our defense efforts. Such care of the farm population assures production of essential agricultural products and a ready reservoir of manpower for armed forces and defense industries.

The Medical Care Program

The medical care program sponsored by the Farm Security Administration is developed in close cooperation with the organized medical profession. No medical care plans are started until a basic agreement or understanding has been reached with the State Medical Association. When a mutually satisfactory understanding has been reached, county or district-wide plans for borrower families are designed.

The medical care program divides itself logically into the following phases, any or all of which may be included in a particular plan: general practitioner care, surgical and other specialist care, hospitalization, and the provision of necessary drugs. Because of the limited ability of borrower families to pay for medical care, the emphasis has necessarily been on treatment of acute illness. Provision has also often been made, however, for the correction of chronic defects which retard rehabilitation. Some medical care plans have included emergency dental care. There is an increasing tendency to organize separate dental care plans with provision for extractions, treatment of infection, fillings and minimum essential restorative dentistry.

The basic principles upon which the medical care plans are founded include close cooperation with State and county medical societies and professional groups representing hospitals and druggists; free choice of physician, hospital and druggist; basing

family participation rates upon the average incomes of borrower families in the area as revealed by farm and home plans; the payment of participation dues in advance on an annual basis, and assistance to borrower families in making such payments, ordinarily through loans.

Typically, the funds for participation deposited by each family are placed in a pooled or common fund in charge of a trustee. An alternative to the trusteeship form of organization is an unincorporated health association organized by the borrowers. Under the arrangement usually followed, annual funds, after deduction of a small amount to cover administrative expenses, are divided into twelve monthly allotments from which bills are paid by the trustee. The bills are paid in full when possible, or on a pro rata basis when funds are not sufficient to pay them in full.

All medical aspects of a plan are under the control of the county medical society. All bills must be audited and approved by a medical review committee before they are paid by the trustee. The chief difference between these plans and private practice is that the physician submits his bills to the trustee of the medical care fund instead of to his patients. There is no interference with the personal relationship between physician and patient.

Farm families on the rehabilitation program participate in these plans by prepaying annual dues, which range from about $15 to $35 per family. The rates for a particular plan depend on the services covered, the average incomes of borrower families in the area, and often upon the size of family. For these amounts, which represent the most that families with very low incomes can afford, they are assured of services which ordinarily include family physician's care, obstetrical care, emergency surgical care, limited hospitalization, and ordinary drugs. Occasionally limited dental care is included.

How a Typical Plan Operates

To illustrate how the medical care plans operate, an example may be taken from a Midwestern State. In the county plan described, which is typical of the plans in several States in the area, the families pay $30 annually for general practitioner care, emergency surgical care, prescribed drugs, limited hospitalization, and emergency dental care required to relieve pain or remove a source of infection.

A deduction of $1 is made from each family's dues for administrative expenses. The funds are then divided into twelve monthly

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allotments. Hospital and drug bills are paid in full each month as preferred charges, and the balance of the monthly allotment is used to pay physicians' and dentists' bills. A record is kept of any bills not paid in full, and at the end of the year any accumulated monthly surpluses are applied against the unpaid balances still owed on such bills.

The county used as an illustration has a population of about 13,000. There are six practicing physicians, seven dentists, three hospitals and seven druggists in the county. All are participating in the program. There were approximately 175 rehabilitation families in the county during the period covered by the following report:

Report of County Medical Care Plan, August, 1939 through July, 1940

Average monthly membership - 162 families, 767 persons.
Total membership dues at $30 per family per year - $4,888.58.

	Approved Charges	Percent of Total	Amount Paid	Percent Paid
All Services	$5497.03	100.0	$4888.58	88.9
Physicians & Surgeons	4327.00	78.7	3745.49	86.6
Hospitals	469.93	8.6	469.93	100.0
Drugs	296.60	5.4	296.60	100.0
Dental	232.00	4.2	205.06	88.4
Ambulance	7.50	.1	7.50	100.0
Administration	164.00	3.0	164.00	100.0

Summary of Services

Cases of illness		819	Drug prescriptions		491
Surgery - Minor	25		Charge per prescription		$0.60
- Major	8				
Obstetrical cases	13		Hospitalized cases		15
Illness per 1000 persons		1068	Hospital days		98
			No. of days per case		6.5
Office calls		1008	Cost per case		$ 31.33
Home visits		143			
Miles traveled (physicians)		1330	Dental cases		96
Hospital calls		117	Charges per case		$ 2.42
Office, home and hospital calls per 1000 persons		1653			

Monthly Payments

Physicians' and Surgeons' Service

	Approved Charges	Amount Paid	Percent Paid
1939			
August	$ 297.00	$ 295.64	99.5
September	349.50	284.47	81.4
October	269.25	269.25	100.0
November	412.00	287.91	69.9
December	446.00	316.05	70.9
1940			
January	218.00	218.00	100.0
February	437.00	284.61	65.1
March	477.50	310.65	65.1
April	283.50	283.50	100.0
May	281.50	272.52	96.8
June	433.00	342.88	79.2
July	422.75	303.51	71.8
Accumulated balances		276.50	
Totals	$4327.00	$3745.49	86.6

Emergency Dental Service

	Approved Charges	Amount Paid	Percent Paid
August	$ 4.00	$ 3.98	99.5
September	21.00	21.00	100.0
October	8.00	8.00	100.0
November	20.00	14.00	70.0
December	23.50	16.64	70.8
January	6.00	6.00	100.0
February	27.50	17.92	65.2
March	14.00	9.10	65.0
April	10.00	10.00	100.0
May	40.00	38.72	96.8
June	21.00	16.64	79.2
July	37.00	30.24	81.7
Accumulated balances		12.82	
Totals	$232.00	$205.06	88.4

Hospital and Drug Services
(All bills for these services were paid in full each month)

	Hospital	Drugs
1939		
August	$ 69.15	$ 10.64
September	67.40	6.55
October	31.50	7.15
November	68.60	16.33
December	27.75	33.89
1940		
January	0	29.61
February	50.50	44.07
March	47.75	35.41
April	22.50	24.43
May	43.88	33.15
June	6.00	22.75
July	34.90	32.62
Total	$469.93	$296.60

Charges for Services Received by Families

Charges for Service	No. of Families
No service	12
0 - 9.99	40
$ 10.00 - $ 14.99	12
15.00 - 19.99	19
20.00 - 24.99	7
25.00 - 29.99	10
30.00 - 34.99	5
35.00 - 39.99	6
40.00 - 49.99	21
50.00 - 99.99	21
100.00 - 149.99	9
150.00 - 200.00	2

Dental Care

The dental care needs of borrower families are no less urgent than their medical care needs. Although emergency dental care, limited for the most part to extractions, has been provided in connection with a considerable number of the medical care plans, there is a steady increase in the number of separate dental care plans being organized which provide more complete dental service. The dental care activities which have resulted from the cooperation of State and local dental societies and the Farm Security Administration must be considered experimental. The general principles upon which many dental care plans are based are similar to those of the medical care program, including free choice of dentist, basing the cost of the plan upon the average ability of borrower families to pay, and placing all dental aspects of any plan under the direct supervision of the dental profession.

Dental care plans for borrower families have been organized separately from medical care plans in ten States. At present, such plans serve more than 20,000 families in over 150 counties. Other plans are being organized.

In general, there are two types of dental care plans. One provides for elimination of infections and such minimum restorative dentistry as may be necessary to place the mouth in a healthy condition. The other type provides certain minimum essential services of an emergency nature such as extractions, the treatment of infections, simple fillings, and preventive care.

Plans of the first type are in effect in several States. The family dentist makes an estimate of the minimum amount of service, including restorative dentistry, required to put the mouths in a satisfactory condition. The estimates are reviewed by a committee of dentists, and individual family funds to cover such essential services as may be within the ability of the family to pay are set up in a special bank account in the hands of a trustee and paid to the dentist upon completion of the work. Loans to cover this type of service are often made on the basis of repayment over three years or more.

Plans of the other general type are found in a number of other States and are typified by those operating in 44 counties in Arkansas. They are designed to meet some of the most urgent dental needs of a very low income group of farm families who have had practically no dental care previously.

In Arkansas the families in a county pay into a pooled fund on an annual basis the basic sum of $3 per family, plus 50¢ for each person in the family or, for example, $5.50 for a family of five.

The fund is divided into 12 monthly allotments and dentists submitting bills for services to those persons who apply for necessary care are paid from the monthly allotments. When funds are insufficient to pay bills in full there is a pro rata distribution of the allotment. Reports indicate that the dentists are receiving an average payment of over 70 percent on bills carrying their usual fees.

A dental care plan, which it is hoped may combine certain of the best features of the two plans described, has recently been approved by the State Dental Association in a Western State. In this plan the families pledge themselves to participate for a five-year period. The participation rates average $20 per family for each of the first two years of participation and $10 per family for each of the following three years. There is free choice of dentist, and the services include an annual examination, cleaning and scaling, extractions, treatment of infections, fillings, and part of the cost of dentures or bridgework. This may prove a solution to the problem of families dropping out of a plan once a certain amount of corrective work has been performed.

Environmental Sanitation

Closely allied to the medical program is the campaign begun in 1938 to improve sanitary facilities on the farms of rehabilitation borrowers. Minimum and basic sanitary precautions will do away with the high amount of typhoid fever, dysentery, malaria, and hookworm disease which affect so many rehabilitation families in certain areas.

The three purposes of the sanitation program are to provide proper disposal of human waste, protection of water supplies against contamination, and screening of homes. Investigation of existing sanitation facilities on borrowers' farms and an estimate of the minimum improvements necessary is made to maintain the health of the families. As most borrowers are tenants, landlords have cooperated to secure these improvements by giving the tenant family a lease of three to five years, as well as making some of the needed improvements. In return for the grants for materials to build privies, dig wells, and screen their homes, borrowers agree to a work program which will contribute to the betterment of the family's farm and home. This calls for work such as construction of trench silos; relocation of barn lots and drainage to protect the water supply; and the repair of steps, fences, or chicken houses.

Sanitary facilities have already been made possible for at least 40,000 families. The rapid spread of the program has been aided by the cooperation of State and county health departments in furnishing technical advice, literature, field inspections and some

supervision; the Work Projects Administration in supplying labor for construction of privies; and the National Youth Administration in using its workshops for building of screen doors, window screens and well slabs.

Health Program in Homestead Projects

In addition to its rehabilitation program, the Farm Security Administration is responsible for 151 homestead projects, many set up by prior agencies. These projects vary widely but they usually make provision for a new start on the land for 100 to 200 families located on nearby farms in the same rural community.

The homesteaders living on 23 of these resettlement projects are taking part in medical care plans meeting the needs of rehabilitation families in the same areas. Separate plans of various types are in effect in 34 other homestead projects. In the great majority of the plans in which homestead families participate, there is free choice of physician. In about a dozen projects, most of them isolated, a physician from a town 15 or 20 miles away has agreed to serve the project on a part-time basis, or a resident physician has been attracted to the project by guaranteeing him a basic income.

Community nurses have been employed by the Farm Security Administration to serve 38 resettlement projects. They conduct a generalized public health nursing program for the families, in cooperation with State and local health departments. In most instances their services extend beyond the project area in order that the program of the county health department may be supplemented or that a county without a health unit may receive the benefit of their assistance.

In a number of projects the homesteaders themselves have taken the initiative in organizing voluntary beneficial associations and have worked out special agreements with physicians and hospitals for the care of their members. In some projects the families pay regular monthly dues in cash without help from the Farm Security Administration; in other projects, the Farm Security Administration lends money to the homesteaders for this purpose, to be repaid when the crops are sold.

Medical Aid to Migrants

Tens of thousands of uprooted farm families, seeking work in the various harvests in Pacific and Atlantic Coast States, and in States such as Idaho, Colorado, Texas, and Michigan, can neither pay for medical attention nor secure it through relief agencies. On the

one hand they have perhaps the lowest living standards of any group in the United States, with incomes usually ranging between $200 and $450 a year for a family, and on the other, they do not meet local residence requirements for relief assistance. Poverty, malnutrition, exposure, and the insanitary conditions under which migrants are forced to live, make them an easy prey to disease. The threat of the spread of communicable disease, as migrants move from one farming area to another in search of work, is a problem which cuts across State lines.

Since 1936 the Farm Security Administration has been helping the States meet some of the most urgent health and housing problems created by this wave of migration. To provide sanitary facilities and temporary shelter, 49 camps, 9 of which are mobile, are operated in California, Arizona, Oregon, Washington, Idaho, Texas, and Florida. Each of these camps has a health center or clinic with a public health nurse in charge, and an isolation unit or center for cases of contagious disease. The State health departments assist in providing immunizations and conducting various preventive activities. Arrangements have been made with State and county medical societies whereby local physicians furnish care at the clinics, usually in rotation. Patients may be referred, if necessary, to surgeons or other specialists, and hospitalization is provided.

Since the spring of 1938, medical care has been provided migrants in California and Arizona through the Agricultural Workers Health and Medical Association, a corporation which the migrants join as members. This non-profit organization, which is subsidized by grants from the Farm Security Administration, is administered by a Board of Directors on which are represented the California State Health Department, the State Medical Association, the State Dental Association, and the Arizona State Medical Association, as well as the Farm Security Administration.

Applications for medical treatment are made at the Association's district offices or at the Camp clinics. A certificate of membership in the Association is issued to the applicant, who selects his physician from a list of those participating. The Association is billed for the medical or hospital services rendered. Payment is also made for prescribed drugs, x-rays and other diagnostic services, emergency dental care, and special diets in cases of malnutrition. Elective as well as emergency surgical care, and urgently needed restorative dentistry, may be authorized by the Medical Director of the Association.

In the camp clinics in California and Arizona local physicians serve at designated hours. Usually certain physicians serve on alternate days, or the county medical society arranges for certain of

its members to serve in rotation, each for two or three months at a time.

Although provision is made for the migrant workers to repay part of the cost of services upon request if they are able to do so, their incomes make repayment impossible in most cases. Some workers have shown their appreciation by repaying a few dollars out of their meager incomes.

By July, 1940, after operating a little more than two years, the Agricultural Workers Health and Medical Association had provided medical aid for 48,693 different persons representing 21,444 families.

Medical care corporations essentially similar to the one operating in California and Arizona have been organized in three other areas, the Pacific Northwest, the Rio Grande Valley in Texas, and in Florida. Although medical aid on a temporary basis was being extended during 1940, to migrants in these areas, fully organized service provided through the associations was first available in early 1941.

Appraisal of the Medical Care Program

Appraisal of the general medical care program is difficult. A wide variety of plans for borrowers has resulted from the collaboration of medical and dental societies in all parts of the United States with field representatives of the Farm Security Administration. The plans have been designed to meet varying local conditions. No plan is static; many have been modified in the light of experience. Most difficulties have been overcome as they have arisen.

When the medical profession in an area has been willing to exercise its proper responsibility for all medical aspects of the local plan, acting through selected representatives, a minimum of difficulty has been encountered in all matters affecting the physicians. Abuse of privileges by the families has been infrequent, and there has seldom been difficulty in controlling it. The heart of the program lies in a clear understanding by both physicians and families as to what the plan provides and how it operates.

The fact that very few plans have ceased to operate, and that many new plans are being organized each month, is an indication that they are reasonably successful and in general satisfactory to both physicians and patients, for the basis of this medical program is voluntary cooperation by both families and physicians.

At its last annual meeting the American Medical Association adopted a report by its Reference Committee on Legislation and Public Relations which included the following statement concerning the Farm Security Administration medical program:

> "The Committee on Legislative Activities has followed the development of the Farm Security Administration plan for medical care of clients. This is obviously an effort to use the insurance principle to pay for medical service. It has been successful in securing cooperation of component county medical societies in many communities and, while acknowledged as experimental in scope, the experience seems to have contributed something to the solution of the medical problems of a farm group which is medically indigent."

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